Typhoid and Its Homoeopathic Management

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Abstract- Typhoid fever is the result of systemic infection mainly by s. typhi found only in men. The disease is clinically characterized by a typical continuous fever for 3 to 4 weeks, relative bradycardia with involvement of lymphoid tissues and considerable constitutional symptoms. The term enteric fever includes both typhoid and paratyphoid fevers the disease may occur sporadically, epidemically or endemically.

INTRODUCTION
Typhoid fever, also known as enteric fever, is a common bacterial infection caused by the salmonella group of bacilli (S. typhi and S. Para typhi). The main clinical feature of the infection is a prolonged high fever. In India, typhoid fever is endemic, and a study conducted in an urban slum revealed that every year, 1 per cent of children up to 17 years of age suffer from this disease.

EPIDEMIOLOGY: [1]
Agent factors:
Agent: S. typhi is the major cause of typhoid fever. S. para A and S. para B are relatively infrequent.
S. typhi has three main antigens - O, H and Vi and several phage types
Phage typing has proved a useful epidemiological tool in tracing the source of epidemics.
Survives intracellularly in the tissue of various organs.
It is killed by drying, pasteurization, and common disinfectants.
The factors that influence the onset of typhoid fever in man are the infecting dose and virulence of the organism.
Reservoir of infection: Man is the only known reservoir of infection.
Cases: May be mild, missed or severe.
A case or carrier is infectious as long as bacilli appear in stools or urine.
Carriers: Convalescent: Excrete the bacilli for 6 to 8 weeks, after which their numbers diminish rapidly. By the end of three months,
Chronic: Persons who excrete the bacilli for more than a year after clinical attack are called chronic carriers.
In most chronic carriers the organism persists in the gall bladder and in the biliary tract.
A chronic carrier may excrete the bacilli for several years either continuously or intermittently.
Faecal carriers are more frequent than urinary carriers
Chronic urinary carrier state is often associated with some abnormality of the urinary tract.
Source of infection:
Primary: faeces & urine of cases or carriers.
Secondary: contaminated water, food, fingers & flies.
Host factors:
Age:
At any age
Highest incidence 5-19 years
Pre-school-age children – less than 5 years.
After the age of 20 years – incidence falls due to the acquisition of immunity from clinical or sub-clinical infection
Sex: More cases are reported among males than females
But the carrier rate is higher in females
Immunity: all ages are susceptible to infection
Environmental Factors:
Observed all through the year but
Peak incidence – July to September because this period coincides with the rainy season and an increase in fly population.
Social Factors:
Personal hygiene and health ignorance.
Water
Drinking water supplies in open-air defecation & urination
Ice
Food
Low standards of food
Vegetables grown in sewage farms
Washed in contaminated water
Milk
Soil for varying periods
PATHOPHYSIOLOGY:
Incubation Period: The incubation period of typhoid fever varies from 10-14 days.
Causes And Transmission fever is caused by salmonella type, a gram-negative bacillus. The disease gets transmitted by 
Faeces or stools of patients and already affected persons.
Contamination of water, milk or other food materials.
House flies play an important role.
Contact with infected persons can also transmit the disease.
Poor maintenance of sanitary arrangements.
The organisms enter and multiply in the bloodstream producing general septicemia. Finally, they settle down in collections of 
lymphoid tissues in the small intestine known as the Peyer’s patches. The classical lesion is an oval ulcer in the longitudinal axis of 
the intestine. Sloughing of the ulcer begins in the second week and the slough separates by the third week. The ulcer assumes 
a sieve-like appearance with rounded margins. Sloughing may cause perforation in the wall of the intestine. Haemorrhage may occur 
from the sloughed-out ulcers. Healing of the ulcers occurs in the fourth week. In carriers, the organisms settle down in the gall 
bladder and continue to be discharged into the faeces.

CLINICAL FEATURES:
Symptoms:-
The onset is insidious and in untreated cases, the disease runs 4 weeks. Fever is the most characteristic feature though headache, 
malaise and a feeling of weakness may be present
Fever – fever rises gradually in the evening but falls slightly the next morning. By the end of the second week, the temperature 
reaches a definite peak level (usually 102 F – 104 F).
The tongue is heavily coated but the margins are clear.
Distension of the abdomen and gurgling in the caecum.
Anorexia, nausea and abdominal discomfort.
Constipated followed by (‘pea-soup’) diarrhoea.
The typical rashes ‘rose spots’ appear by the end of the first week. There are small, round, raised spots mostly on the upper part of 
the abdomen and the chest.
The spleen is palpable and soft in consistency.
In severe infection – the patient becomes drowsy and mentally confused. He talks incoherently in a slow voice (muttering delirium), 
pulls up imaginary threads or picks up the bedclothes. He presents a vacant staring look and is unaware of the surroundings. This 
state is known as typhoid state or typhoid encephalopathy.
Haemorrhage and perforation may occur, usually after the 14th day of fever.

COMPLICATIONS:
Haemorrhage – it occurs during the second or the third week due to the separation of slough in the Peyer’s patches. If severe, the 
patient passes into shock.
Perforation – it usually occurs in the third week. There is sudden acute pain in the abdomen and vomiting.
Typhoid encephalopathy.
Bronchopneumonia.
Thrombophlebitis.
Parotitis.
Cholecystitis
Osteomyelitis
Arthritis, myositis
Toxic myocarditis

INVESTIGATIONS:
Total Differential leukocyte count.
Differential leukocyte count
Serological test–
Widal test:
The test depends on the presence of typhoid antibodies in the serum. Since antibodies take time to develop, the test is positive only 
after the 10th day. The serum of the patient is mixed with known typhoid bacilli. Agglutination occurs if the serum contains the 
specific antibodies. The typhoid bacillus has 2 types of antigens, one derived from the body (somatic or ‘O’ antigen) and the other 
derived from the flagella (flagellar or ‘H’ antigen).positive agglutination in rising titres of ‘O’ antigen (above 1;160) is diagnostics. 
Culture of bacilli:

TREATMENT AND HOMOEOPATHIC MEDICINES FOR TYPHOID:
Baptisia – unusual fetidity, besotted expression, mental depression. [2]
Chill, with rheumatic pains and soreness all over the body. Heat all over, with occasional chills. Chill about 11 am. A dynamic 
fever. Typhus fever. Shipboard fever. [3]
Rhus tox – early stage with restlessness brown tongue muscular soreness, muttering delirium. The patient is usually having 
Diarrhoea. [2]
**Bryonia alba** – great soreness, tired feeling, patient usually has constipation. [2]

**Arnica** – bruised feeling, stupor, indifference, involuntary stool and urine. [2]

**Arsenicum album** – terrible prostration with irritability and anxiety, cold sweat and delirium. [2]

**Carbo veg** – lies pulseless and cold feet and legs, the patient wants to be fanned for cold extremities. [2]

**Muriatic acid** – great weakness, foetor breath and ulceration of mucous membrane. [2]

**Phosphorous** – typhoid complicated with pneumonia. [2]

**Hyoscyamus** – typhoid with low delirium and muscular twitching [2]

**APIS** – Diarrhoea in eruptive fever [4]

Afternoon chill, with thirst; worse on motion and heat. External heat, with a smothering feeling. Sweat slight, with sleepiness. Perspiration breaks out and dries up frequently. Sleeps after the fever paroxysm. After perspiration, nettle rash, also with shuddering. [3]

**SAMB** – Cough dry deep, precedes the fever paroxysm [4]

**NAT MUR** – Intermittent fever paroxysm at 10 or 11 a.m. [4]

Chill between 9 and 11 am. Heat; violent thirst, increases with fever. Fever-blisters. Coldness of the body and continued chilliness are very marked. Hydroaemia in chronic malarial states with weakness, constipation, loss of appetite, etc. Sweats on every exertion. [3]

**CACT** – Fever paroxysm at 11 a.m. & 11 p.m. [4]

**Antipsoric remedies for typhoid as per Dr E.B Nash** – Sulphur, calcarea, lycopodium, silica. [5]

**3 Mark remedies from Murphy’s repertory for typhoid fever**

**Typhoid, fever, Salmonella**

Ars, bapt, bry, carb- veg, chin, colch, gels, hyos, lach, merc, mur-ac, phos, rhust. [6]

**DIET:**

The diet should be bland and easily digestible.

Liquid items such as milk, Horlicks or fruit juices.

Avoid meat, chicken etc.

Well-cooked rice, sweetened rice, and loaf crushed in milk should be given after the patient improves and the temperature settles down.

No solid items should be given for 3 days.

**CONCLUSION**

Typhoid cases respond very nicely to homoeopathic medicines. and still, it seems the bright scope of homoeopathy is ahead in this field as per my experience.

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